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LECTURES.

CLINICAL LECTURE ON ANIMAL PARASITIC DISEASES OF THE SKIN.

DELIVERED AT THE NEW YORK HOSPITAL.

BY L. DUNCAN BULKLEY, M. D.

Scabies. — GENTLEMEN: The young man whom I now show you is the subject of scabies, but unless you were to examine his case very carefully, you would hardly be led to suspect that this was the nature of his trouble. The main lesion which he presents, and to which he directs our special attention, is upon the right arm, near the elbow, where there are a number of extremely thick crusts grouped together; and the same thing is also found on the left arm, though in a less marked degree. These, however, are secondary lesions, and are merely the results of scratching, and you must look elsewhere if you would determine the true nature of the trouble in this case. The place of all others to look for the characteristic evidences of scabies is between the fingers, and after this about the wrists and upon the soft parts of the hands. In the present instance I did not at first recognize what the trouble really was; but the moment I looked at the hands I began to suspect that it was scabies, and a more careful examination of the case revealed three of the characteristic features of the disease. These were, —

First, isolated scratched papules between the fingers. Such a condition is extremely rare in eczema.

Second, one or two of what are called the cuniculi or furrows on the skin. Here, however, they are very faint, but there is one little line which is quite distinct. This is often the nearest that we can get to a furrow, but it is quite sufficient to prove the character of the affection present. The furrows are generally seen as small black lines (the dark color being due partly to the eggs and fæces of the insect in them, and partly to dirt), but sometimes they are whitish in appearance.

Third, a crust upon the glans penis. It was a French observer who first pointed out the fact that where there is such a crust (or perhaps a papule), or perchance several exist on the penis or on the scrotum we are almost certain to find scabies present upon the person. It is also not at all unusual to find well-marked furrows on the penis.

In addition, in this case, you see about the legs, and notably on their softer parts, a widely diffused multiform eruption, characterized in some places by small papules and in others almost by furuncles, and due indirectly to the same general cause, scabies, or rather to the scratching accompanying it.

The eruption of scabies, as I have remarked, is most frequently seen about the hands (and especially is this true of strumous children), but you will sometimes meet with individuals suffering from the disease upon whose hands you will look in vain for any evidence of its presence. The eruption may be situated on the arms or other parts of the body, and not a little difficulty may be experienced in the search for the location of the cuniculi or furrows, which are the sole pathognomonic sign of the disease. This one lesion which is perfectly pathognomonic is the little dark furrow (sometimes called cuniculus), which looks like a piece of fine black thread or silk in the skin. It is not, however, quite so black, and may be either curved or straight; its length varies from a sixteenth to a fourth of an inch. Such a furrow, which is generally found to terminate in a papule, vesicle, or pustule, is made by the female insect, which always burrows, while the male simply wanders over the surface of the skin. The moment she becomes impregnated she seeks a hair follicle or some natural orifice where she may get beneath the horny epidermis, and at once begins to burrow and to lay eggs. These are left all along the track in which she advances, until she gets so deep in the tissue that a papule or vesicle results from the irritation produced. As she proceeds on her way the older eggs are hatched out, and the empty shells may be seen when we excise the skin containing such a furrow, but the newer ones are all found to contain insects; while in addition to the eggs little specks are seen here and there along the track, which are supposed to be fæces. In a short time after commencing her burrowing she dies. The furrows are very apt to be scratched open by the fingers of the patient, and thus the young insects are allowed to escape. The technical name of the insect is the *acarus*, or *sarcoptes scabiei*.

At the end of the furrow will usually be found the vesicle or papule. When the furrow is ascertained to be present the diagnosis is certain, but another sign almost as sure, in males, are papules or pustules on the penis, such as are met with in no other affection, as was seen in the case just before us; they are sometimes found in connection with a furrow, and sometimes not; they are of course to be distinguished from a papular syphiloderm. In females the lesions may be principally located about the breasts. Hardy states that in unmarried females with what appears to be eczema of the breast he always suspects scabies. In children, on the other hand, they are generally found upon the soft parts of the foot, and here you may sometimes see the furrows very

beautifully perfect. The plates which I now show to you will give you a fair idea of the different manifestations of scabies under different circumstances, and also exhibit magnified views of the furrows containing eggs, as well as the male and female insects themselves.

In scabies we can never be sure of a complete cure as long as a single furrow remains, because it will serve to perpetuate the colony of insects; but, as the matter is arranged in Paris, it takes only two hours to insure the patient's complete recovery. Of course, the arrangements there for the treatment of scabies are very perfect; but just as satisfactory cures can be made here (although not perhaps in such a short space of time) if the proper method is employed. The plan that I recommend is as follows: The patient should first take a warm bath, remaining in the water for half an hour, after which he should be well rubbed for a considerable time with the coarsest soap that can be procured, and be again immersed in the bath. Then he should apply whatever ointment is ordered in the most thorough manner, rubbing it in diligently, especially about the fingers and wrists. The idea of this is to have it brought in immediate contact with all the furrows.

As to the character of the ointment to be employed we must be governed by circumstances. In infants, on account of the delicacy of the skin, we sometimes cannot use sulphur ointment at all, and in such cases a very excellent substitute for it will be found in liquid storax, officinally known as styrax. It may be used in the proportion of from one to three drachms to the ounce of simple cerate. For scabies in females the following is a very satisfactory combination: —

℞ Styracis . . . . . 3j. ad 3ij.
Unguenti sulphuris . . . . . 3iij. ad 3iv.
Cerati . . . . . 3j. M.

In males we very frequently use the sulphur ointment in its full strength, but in the present instance I think it will be sufficient to employ it diluted one half, at the same time adding to the salve a little styrax or balsam of Peru. Then we must not neglect to charge the patient to pay particular attention to its application to the fingers, wrists, and penis, for it is, as I mentioned before, an essential element of success that it should be worked in, especially in these localities, in the most careful and patient manner. If he does this according to the directions given him, there can be no doubt of the result, and that the cure will be as prompt as it is complete. You should always have the clothing treated by heat of at least 212° Fahrenheit; the clothes may be boiled, or, as in the case of phthiriasis or body-lice, I frequently have them rolled in a bundle and laid in the oven, and submitted to a good baking, a board being placed beneath them to prevent scorching.

PENETRATING GUN-SHOT INJURY OF THE ELBOW AND KNEE JOINTS.

BY J. F. BUSH, M. D. HARV.

In February, 1878, I had under my care a patient with pneumonia. There was nothing of unusual occurrence in the course of the disease, and the case would not have been brought before the profession but for a peculiar gun-shot wound which was made interesting by the result of the post-mortem examination. When I saw him he had pleuro-pneumonia, and after a few days' illness died. At various times during these few days he complained of pain in his left arm, which he attributed to his wounds, and upon inquiring I found that he had received wounds through the left elbow and the left knee during the war of the rebellion, and had at that time been under the care of Dr. J. Mason Warren, who gave the following history in his book, Surgical Observations, with Cases and Operations, page 563: —

"A young officer, twenty-five years of age, while stooping down, at the battle of Antietam, to tie his handkerchief around the thigh of the man next to him, who was bleeding to death, his leg having been shot away by a cannon ball, received a shot which passed diagonally through his elbow-joint and entered and lodged in his knee-joint. The elbow at the time was bent, and from the position it was in laid flat against the knee-joint. A great spout of blood at once took place from the inner wound of the arm, indicating that some large vessel had been cut off. He checked the hæmorrhage with a leather strap buckled tight around his arm. . . . . He limped off on his injured leg to the nearest ambulance station, where the wound in his knee-joint was examined by a surgeon. The probe penetrated the joint freely, but the ball could not be detected. From the strongly bent position of the limb it had apparently escaped the tibia and passed in between the condyles of the femur, where it was securely lodged and concealed. His arm and leg had water dressing applied and were put in splints, and he was immediately placed in the cars and transferred to Boston, where he arrived in the course of a week with many other soldiers, some of whom had received equally serious wounds, and to whom the danger of transportation, except under existing circumstances, would have been considered almost a fatal movement. When I saw him he was in an extremely feeble condition. Belonging to a fresh body of troops, he had been marched some days before the final battle, and fought for one or two days before, subjected to great heat, his principal nourishment being green corn, which produced an almost constant diarrhœa. It is probable that to this condition he owed his safety. In addition to the above wound he was suffering from a contusion of his side. The knee-

joint I found was free from pain and inflammation, but the wound on its outside slightly suppurating. It was dressed with a ham-splint, and kept in a state of perfect rest. On examining the elbow-joint I found it quite loose, both condyles broken off, the joint swollen with an effusion; on the inside a bullet hole, below the joint on the outside and above it on the inside. The elbow was made immovable with splints; and after a moderate amount of inflammation, which at any time did not amount to anything threatening, both the knee-joint and the elbow-joint did perfectly well, so that at the end of two months he was able to go out-of-doors. He finally recovered all the motions of his elbow-joint. Now, at the end of four years, he walks without the least sign of lameness, the ball still remaining in the knee. The power of entire flexion of the leg only is wanting."

Concerning the subsequent history there is little to say. The motion of the arm increased by use, so that there was the power of complete extension, but flexion was to a degree limited; not enough to make any practical difference, but sufficiently to show that there was some trouble about the articulation. The strength of the arm was somewhat less than that of the other, but the patient being a book-keeper he had no necessity for manual labor, and, undoubtedly, had he exercised, the strength would have increased in proportion. The arm was a barometer to him, for every storm was predicted to a certainty by pain. The condition of the knee was better than the elbow as far as motion was concerned, for after the first lameness caused by the inflammation had subsided he was able to flex and extend the limb, and could walk or run without pain or inconvenience. The knee had been particularly free from pain until within eighteen months, during which time he had often observed to his friends that "he knew that ball was still in his knee, for it pained him;" and when they suggested rheumatism, he — having had rheumatic fever a year before, — would reply, "It is not that kind of a pain; it is something entirely different. I know the ball is there."

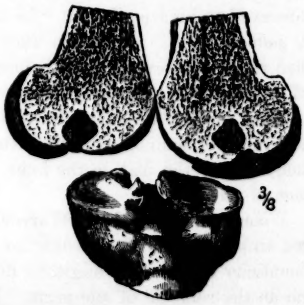
After his death his friends, having in their own minds a doubt and difference of opinion as to the extent of the injuries and in the possible lodgment of the ball in the knee, consented to a post-mortem examination of the parts.

Upon calling Dr. J. C. Warren's attention to the case, he furnished me with a copy of the account as given above, without which the authenticity of the case might be doubted, and he kindly offered to assist me in the removal of the parts. Upon examination of the left arm two irregular cicatrices were discovered, — one on the outside below the elbow, the other on the inside higher up, showing that the joint had been traversed diagonally. Motion could not be detected. As the body had been packed in ice the muscular rigidity was great. The joint was removed as for resection. Upon forcibly flexing the arm numerous

fibrous adhesions were found; some were broken down, but others were so hard and firm that they did not give way, and a portion of the coracoid process was broken away in their place. Small particles of lead, the largest the size of a millet seed, were found imbedded in the muscular tissue.

As a careful and minute description of the specimen can be found in the catalogue of the Army Medical Museum, written under the faithful supervision of the curator, I give the gross appearances only. The condyles of the humerus were broadened, thickened, displaced, and irregular, studded with spiculæ. The olecranon showed signs of injury, and the head of the radius was thickened. Upon section, the internal condyle was found to have been broken into two pieces, the fracture extending into the joint. The external condyle was fissured. The union was ligamentous, though from a peculiar cracking sound heard while the parts were in a vise while the section was being made, it is safe to say that there was osseous union at the outside. By far the most interesting part as revealed by the examination was the knee. An oval cicatrix as large as a dime was discovered below the external condyle of the femur and below the patella.

Upon opening the joint and removing the semilunar cartilages, there was found a "gouged" wound of the tibia at the articulation with the condyle of the femur. The tibia showed no signs of disease, only an oval piece gouged out. The external surface of the femur presented on its articular face an oval cicatrix, half an inch by three fourths of an inch, on the cartilage; the rest of the bone seemed to be normal, there being nothing of pathological interest until a longitudinal section was made. A mass of lead was found imbedded in the cancellated tissue of the condyle just beneath the cartilage, which had grown over it entirely. This mass was of good size, and nearly round. About the lead was a slight deposit of lime. The cancellated structure in the immediate neighborhood was more compact than elsewhere, but the amount of irritation it had produced was slight. From the nature of the wound



it appeared that the elbow was not only bent and against the flexed knee, but that the ball must have come from a lower plane. The ball was cleaned and its irregularities taken off by its passage through the arm, which may account somewhat for the little trouble it caused in the knee.

The specimens have been forwarded to the Army Medical Museum, and are numbered 6811, 6812, Section 1. The electro-plates which are used to show the position of the ball and the appearances of the elbow were loaned me by Dr. George A. Otis, curator of the museum, and were made for the catalogue and for the third volume of the Surgical History of the War of the Rebellion.

A CASE OF CUTANEOUS CALCULUS.

BY EDWARD J. FORSTER, M. D.

On March 23, 1878, I removed from the face of an Irish servant girl a small, hard tumor, which on a casual examination had the appearance of a urinary calculus. It was situated about midway between the outer angle of the left eye and the tragus of the ear. When an incision was made, it was found to be imbedded in the fibrous tissue of the skin, and was easily dissected out with the handle of the scalpel.

Of its history very little could be learned; the patient thought that she first noticed it some half dozen years ago, dating its commencement from a fall. After it was first seen it continued to increase for about six months, remaining stationary ever since. The calculus is of an oval shape, weighs, after being sawed in two, .95 grammes, measures in length .16 centimetres, in breadth .12, and in thickness .08.

Prof. Edward S. Wood, who kindly made a chemical analysis, reported as follows: "It contained but little organic matter, consisted of epithelial *débris* and a little fatty matter. The bulk of the calculus was made up of phosphate of lime, but it also contained a little carbonate of lime." The tumor was probably at first atheromatous, afterwards becoming calcified.

Virchow in his work on tumors, under the head of Atheroma, says, "In the subsequent history of an atheroma it often ceases in its development, and if small then produces no further trouble. Ordinarily calcification of its epidermic cells takes place either externally, forming a sort of shell, or internally, the contents then becoming mortar-like; or the entire mass is converted into a chalky substance. There is a preparation in our collection of a scrotum studded with calcified atheromas varying in size from that of a hemp seed to that of a bean."

Duhring, in his Diseases of the Skin, says, "In connection with

milium the so-called stones of the skin, or *cutaneous calculi*, may be referred to. They are usually milia or sebaceous concretions, which have undergone metamorphosis into hard, calcareous, or stone-like masses; they are met with only rarely."

Professor Fitz, who has examined the specimen, says, "It is remarkable for the almost ivory-like character of the surface, due to the extreme density of the calcification."

The specimen, which was shown to the Boston Society of Medical Observation, has been deposited in the Warren Museum of Harvard University.

SUBPERIOSTEAL RESECTION OF A PORTION OF THE TIBIA.[1]

BY E. H. BRADFORD, M. D.

M., a child twenty months old, was brought to the Children's Hospital with a sinus in the left leg, at the junction of the middle and lower thirds. The tibia was enlarged in the lower two thirds of its length. The child was quite pale, but in fair flesh. There was slight if any enlargement of the epiphyses at the wrists and ankles. The right knee was swollen and stiff, and there was a cicatrix of a healed abscess in the calf, and also at the base of one of the toes of the left foot. The child had been brought up at the breast, and is reported to have had fair health. The sinus had existed for several months, had occasioned no pain, and had appeared without known cause.

Under ether the cavity into which the sinus led was examined with a probe; a small sequestrum was removed. The bone was found to be extensively diseased throughout the whole lower epiphysis, which had become simply a bag full of carious bone retained by the periosteum and a thin layer of firm bone. The medullary canal of a greater part of the diaphysis was enlarged and filled with cheesy matter; the bone itself was soft, and honeycombed with caseous deposits. There was no pus. An incision was made through the skin and the periosteum; the latter was thickened and loosely adherent. It was readily stripped from the adherent bone. A chain saw was passed beneath the tibia, and the bone was sawn off three fourths of an inch below the junction of the upper epiphysis with the diaphysis. On lifting the bared bone from its position it broke at the lower part within three fourths of an inch from the ankle-joint, at a place where little but periosteum remained. The upper fragment was then removed; the lower portion (which consisted of the lower epiphysis) was so thoroughly disorganized that no attempt was made to remove it, and it was scraped out with a sharp-edged curette.[2] The periosteum and a thin layer of

[1] Read before the Boston Society for Medical Improvement.

[2] Sédillot's Évidement des Os.

bone were left, and the cartilage at the ankle-joint. The cavity was filled with balsam of Peru and oakum. A straight side-splint was applied to the outside of the leg. The wound was left open. The constitutional effect of the operation was slight. On taking off the dressing on the following day granulations could be seen budding from the inside of the periosteum. The granulations increased, and gradually filled nearly the whole cavity. The granulations from the sawn end of the tibia were most rapid in growing, those from the stripped periosteum the next, while the granulations from the epiphysis were slower.

The child did well for a month, then suffered from a light attack of measles, after which the granulations became pale and flabby, and there was little attempt at further granulation or the formation of bone. A small abscess formed below the outer malleolus on the affected limb, and later a second one at the right wrist. During the extremely hot weather of July the child failed noticeably, and died after a severe attack of diarrhœa, three months after the operation.

The mass filling the cavity caused by the removal of the bone was examined after death. Bone was found to have developed at the upper portion and in the epiphysis, and also on the outer side; from the middle of the periosteal flap on the inner side no bone had been developed.

The number of cases of subperiosteal resection of the tibia for disease is not large. I have found records of the following: (1.) Jambon and Aubert.[1] Man, twenty-one years old; removal of four inches, lower end of tibia, shaft and lower epiphysis, for suppurative ostitis. Recovery with useful limb. (2.) Holmes.[2] Boy, ten years old; removal of whole diaphysis. Recovery with useful limb in eight months. One and one half inches shortening. (3.) Holmes.[3] Boy, seven years old; removal of a portion of the diaphysis. Amputation was subsequently performed, with recovery of the patient. (4.) Lentenneur.[4] Patient twelve years old; suppurative periostitis; removal of whole of shaft. Recovery in seven months. (5.) Larghi.[5] Patient twelve years old; chronic ostitis; removal of eight inches of the shaft; epiphyses left. Recovery with useful limb in four months and one half. (6.) Creus y Manso.[6] Patient fifteen years old; removal of entire diaphysis; the epiphyses were sound. Perfect restoration in two years. (7.) Cheever.[7] Patient thirteen years old; suppurative periostitis; removal of entire diaphysis and lower epiphysis. Recovery in eight months, with a useful limb; shortening of three fourths of an inch. (8.) Buckingham.[8] Patient eight years old; suppurative periostitis; removal of diaphysis. Recovery with a useful

[1] Vide Ollier, Traité de la Regénération des Os.
[2] Vide Surgical Treatment of Children's Disease, page 391.
[3] Ibid., page 395. [4] Vide Ollier, loc. cit. [5] Vide Ollier. [6] Vide Ollier.
[7] Boston City Hospital Reports, first series, page 362.
[8] Ibid.

limb. (9.) Ropes.[1] Removal of diaphysis; details not given; patient recovering. (10.) Duplay.[2] Patient sixteen years old; removal of entire diaphysis; the epiphyses left. Recovery, with two cm. shortening. (11.) Varich.[3] Patient nineteen years old; five and three eighths inches of the tibia removed. Complete recovery, with one fourth inch shortening. (12.) Fuqua.[4] Patient sixteen years old; chronic disease of bone; eight and one half inches of the tibia removed. Recovery. Giraldés,[5] McDougall,[6] Newland,[7] Moore [8] (two cases), are reported to have done the operation successfully. Langenbeck, Neudörfer (twelve cases), Kempter,[9] Conant,[10] have performed the operation for disease following gun-shot injury and accident.

Of the cases which I have been able to collect, recovery took place in all except in the one reported by Mr. Holmes, where amputation was performed subsequently.

The death in the case here reported may be fairly attributed to the age of the child and to the effect of intercurrent disease.

The bone removed subperiosteally was two and one fourth inches long and three and one fourth inches in circumference. The portion curetted was one half inch long.

RECENT PROGRESS IN THE TREATMENT OF CHILDREN'S DISEASES.

BY D. H. HAYDEN, M. D.

Tracheotomy in Membranous Laryngitis; the Indications for its Adoption, and some Special Points as regards its After-Treatment.[11] — The surgeon is often called too late, after all therapeutic measures have failed, these generally including depressants. Recession of the chest wall is a more important indication for operation than the loud clanging cough. In most urgent cases the voice and cough are all but abolished, owing to the implication of the vocal cords. Mr. Parker recommends administering chloroform previous to the operation, and has never seen any ill effects from it. The higher operation is preferred as the most

[1] Boston City Hospital Reports, first series, page 362.
[2] Schmidt's Jahrbuch, 1876, Bd. 171, page 66.
[3] New York Medical Journal, January, 1878, page 56.
[4] Richmond and Louisville Medical Journal, April, 1878.
[5] Schmidt's Jahrbuch, 1875, Bd. 166, page 268.
[6] Schmidt's Jahrbuch, 1876, Bd. 166, page 268.
[7] Richmond and Louisville Medical Journal, April, 1878.
[8] Ibid.
[9] American Journal Medical Sciences, January, 1866, page 279.
[10] New York Medical Journal, vol. i., page 84.
[11] A paper read before the Royal Medical and Chirurgical Society at a meeting held November 26, 1878. London Lancet, November 30, 1878.

easy in children, and the tracheal dilator advocated in preference to the immediate introduction of the canula; in this way the tracheal wound is kept open. As a matter of routine he also advises that the trachea and glottis be thoroughly cleared of all foreign matters, whether membrane or mucus, before the introduction of the tube. A feather is usually employed, being passed downwards towards the trachea, upwards into the larynx and through the glottis. The presence of membrane or of inspissated mucus in the larynx above the tube after tracheotomy is often an unsuspected cause of reflex irritation and cough. The surgeon ought every now and then to clear out the larynx so long as the patient is unable to do it himself. Mr. Parker advocates the largest size tube which can be got into the trachea without violence, and the shortest consistent with safety; he lays stress on the advantage of the tracheal part being freely movable. As to the curve of the tube, the outline should approximate the Gothic rather than the Roman arch; in other words, tubes should be made in the form of quarter circles. The forms usually in vogue are not recommended, for it can be shown that such tubes must almost necessarily impinge on the anterior walls of the trachea, and so produce mischief. Mr. Parker believes that a large proportion of the trouble which in past years has arisen from the use of "rigid" tubes has been caused by "ill-fitting" tubes. In speaking of Mr. Baker's flexible tubes, the reader was rather inclined to doubt the expediency of regarding them as less likely to produce ulceration than rigid ones; for unless the flexible tubes are made of a suitable curve they will most probably lead to ulceration just as certainly as (though perhaps less rapidly than) rigid ones. The great indication for operation being the presence of a mechanical impediment to respiration, so the chief object of the surgeon in after-treatment should be to prevent its recurrence. Besides the feather another important aid is the employment of steam. The amount varies in individual cases, but an excess is always to be avoided. The less the tracheal secretion, the more steam is needed, and the converse. Creasote, carbolic acid, benzoin, and other medicaments may be added to meet the requirements of various cases. "Solvents" are particularly recommended, and the most important of them is soda, ten or twenty grains to the ounce of water, to be sprayed into the throat from time to time. It is thought to soften membrane, and also to render its re-formation less possible. Mr. Parker has seldom seen cases where the death could be attributed to the operation, pneumonia and collapse being the commonest causes. The paper concludes thus: "Bearing in mind that the operation is undertaken, not as a curative measure, but simply with a view to the relief of a mechanical impediment to respiration; seeing, nevertheless, the great frequency with which, after tracheotomy, the trachea and larynx on the post-mortem table are found covered, not to say choked up, with mem-

branous exudation (specimens of which may be found in almost every anatomical museum), the author, as a practical outcome of his paper, and with the view to raise a definite issue for discussion, feels justified in enunciating the following dictum: The presence of membrane in the trachea in a fatal case of membranous laryngitis after tracheotomy must be regarded as evidence of the want of due care on the part of the surgeon in charge, just as much as would be the presence of a piece of gut in the inguinal canal after herniotomy, or of a calculus in the bladder after lithotomy."

Mr. Parker's paper gave rise to an extended discussion.

Mr. T. Smith indorsed the paper highly, and bore testimony to the energy with which, when house-surgeon to the Great Ormand Street Hospital, Mr. Parker had carried out the after-treatment of cases which he himself would have deemed hopeless. He had often seen him suck out membrane from the trachea.

Mr. Holmes said that the author's suggestions were of great value; and that now, after Mr. Parker's paper and Mr. Smith's testimony of the value of the practice, he should alter his procedure, which had previously been to abstain as much as possible from irritating the trachea. In answer to Mr. Holmes, Mr. Parker stated that he had performed tracheotomy in cases of membranous laryngitis seventeen times, with eight deaths. Mr. Holmes, resuming, said that this rate was wholly unfamiliar to surgeons, and should lead to the general adoption of the lines of practice suggested in the paper. He did not think that many surgeons used the flexible tubes; and in one case of tracheotomy for cancer of the larynx, in which the trachea was too sensitive for metal tubes, he had found that the flexible tube caused as much if not more irritation, and had to be discarded.

Dr. Charles West, the president, said that in his whole consultation practice he had never regretted a case of tracheotomy. He had often felt sorry that the operation was not sooner performed. He regarded the retraction of the soft parts the most trustworthy indication for the operation, and was accustomed in every case to expose the abdomen and chest, and, according to the degree of retraction, to draw conclusions as to the expediency of operating. He regarded Mr. Parker's statements as sound and wise.

In answer to several members who advocated strongly the flexible tubes, Mr. Parker said that he did not wish to deprecate their use, but thought that they should be tried on their own merits; and that the evils of non-fitting rigid tubes should not be taken as evidence in favor of elastic tubes, the curve of which he believed could not be altered in the trachea without causing pressure. He would rather compare the two kinds to the silver and flexible catheter, — each useful in its own way. In reply to Dr. Marsh he said that the paper was a summary of

the subject, but he did not know of any text-book where the treatment of the trachea as here laid down was emphasized. Necessity for curtailment prevented reference to Trousseau and other earlier workers in tracheotomy.

Diphtheria and Tracheotomy. — Settegast.[1] There were treated between 1873 and 1876 481 children with diphtheria, and tracheotomy was performed in seventy-eight per cent. of the cases, — 375 times. The 106 children upon whom tracheotomy was not performed are classified as follows: (1.) Mild cases of diphtheria. (2.) Cases in a moribund condition when brought to the hospital. (3.) Delicate children under two and a half years of age. (4.) Cases where there was a high degree of infection, but no stenosis of the larynx. Of these cases 46.2 per cent. recovered.

Where tracheotomy was performed nearly thirty-two per cent. recovered, and this percentage is quite a constant one; for, of the 754 children operated on between 1861 and 1876, 31.16 per cent. recovered. There was naturally a variation in different years, 1866 being the best (48.14 per cent. recoveries), and 1868 the worst (20.3 per cent. recoveries).

The greatest number of tracheotomies was in the fifth year; there was then a diminution both ways, suddenly and rapidly to the ninth year, then gradually to the fifteenth. The mortality was one hundred per cent. in the first two years of life. In the third year 23.65 per cent. recovered. From the third to the ninth year the proportion of recoveries rose by degrees forty-five per cent., the eighth year alone proving an exception, with 28.86 per cent. of recoveries. From the ninth year the prognosis became again unfavorable.

A large proportion of the cases were affected with scarlatina and albuminuria. There was seldom a complication with measles, which, however, when present, affected the prognosis unfavorably. Diphtheria of the operation wounds happened rarely, as did also hæmorrhage and purulent mediastinitis. There was often emphysema, which, however, was of no significance. Up to the eighth year the inferior operation was almost exclusively practiced. For the last two and a half years inhalations were employed after the operation, but they did not improve the mortality-rate. Removal of the canula was difficult in only two cases. One patient was still wearing the instrument; with the others it was left out after a few weeks.

Ætiology of Spasmus Glottidis Infantum (Asthma Rhachiticum).[2] —Prof. Z. Oppenheimer, Heidelberg. This disease has been generally

[1] Report of the Surgical Department of Hospital Bethanien, Berlin, 1873–1876. Langenbeck's Archiv, xxii., page 875. Centralblatt für die medicinischen Wissenschaften, November 16, 1878.

[2] Deutsches Archiv für klinische Medicin, June 12, 1878.

regarded as due to a spasm of the laryngeal muscles. The symptoms, however, as is well known, differ very much from those observed in adults when affected with a cramp of these muscles. The author shows the untenability of the hypothesis that the disease is the same in the two cases, and that the difference in the symptoms is due to anatomical and other peculiarities in the infant. It is universally agreed that the most constant symptom, and, in the simplest form of this disease, the only symptom, is the apnœa ; and experience, as well as the large array of experiments that have been made in the study of dyspnœa, rejects such an idea as that this apnœa is the result of a mechanical impediment to the entrance of air.

Oppenheimer finds in the experiments of Rosenthal on the movements of respiration and their relation to the vagus nerve (Berlin, 1862) "facts that are able in every respect to make clear and explain the nature of this disease," and which "are entitled to be looked upon with reference to the disease in question as *experimenta ad hoc;* and scarcely could a second disease in the pathology of the nervous system be so thoroughly sought out with regard to its nature as has been the spasmus glottidis infantum by Rosenthal's experiments." These experiments, which the author reproduces quite fully in this article, have reference principally to the effects upon respiration of irritations of the superior laryngeal nerve; and the symptoms produced are shown to be quite similar to those present in the disease in question.

In place of the electrical current which Rosenthal makes use of in his experiments, the same results would be expected from a mechanical irritant in the form of pressure upon the vagus, capable of rapidly arising and as rapidly disappearing, such as, for instance, would be caused by the pressure of the finger upon the vagus in the neck. A possibility of such pressure is to be found in the foramen jugulare where the nerve and vein lie together, separated by the intrajugular ligament; but only when from some cause or other this ligament has become relaxed, and has thus ceased to exercise its protective influence over the nerve, and to prevent pressure upon it by the distended jugular vein. In one autopsy of a fatal case of this disease, Oppenheimer was able to convince himself, with the aid of the forceps, that this change had taken place, and that the ligament was longer and more relaxed than normal. The author finds in rhachitis, which in a great majority of cases is associated with the disease in question, the cause of the changes above described in the ligament. The vagus, glosso-pharyngeal, and accessorius nerves are all situated in this bony canal; and by a minute description of their relative positions it is attempted to show that the accessorius is more protected and would be less likely to be acted upon by pressure, unless this were excessive. Whether pressure is ever exercised upon the accessorius nerve Oppenheimer does not venture to say;

but, if such be the case, it would tend to explain those puzzling cases where apnœa passes into death, without convulsions or symptoms of violent dyspnœa, through paralysis of the heart.

To fulfill the conditions necessary to carry out this theory, the question arises whether the symptoms preceding a paroxysm are those capable of inducing stagnation of blood in, and a consequent dilatation of, the internal jugular vein. The answer is to be found in the fact that the attack itself comes on during crying, laughing, drinking, a fright, some sudden impression on the senses, — in short, is ushered in by some exciting cause which disturbs the rhythm of respiration, impeding inspiration and prolonging expiration.

If the vagus contain alone centripetal fibres, or if centrifugal fibres are mixed with them, is still a question; but from a clinical stand-point we can accept it as a fact that by irritation of the vagus it is principally centripetal fibres that are put in a condition of irritation.

Spasmus glottidis infantum is therefore regarded by the author as the result of an irritation of the centripetal fibres of the vagus, the result of pressure of the dilated vein in the foramen jugulare, due to a pathological relaxation of the ligamentum intrajugulare, the result of rhachitis. On the ground of this hypothesis he proposes the name asthma rhachiticum.

The explanation of the general convulsions that at times make their appearance Oppenheimer seeks for also in Rosenthal's experiments. By these experiments we know that during the irritation of the vagus nerve apnœa after a time ceases, owing to the great stimulus produced upon the centre of respiration by the supervening want of oxygen, which overpowers the irritated vagus. This want of oxygen irritates also the centre of convulsions (*Krampfcentrum*) in the medulla, causing general convulsions, and if the muscles of respiration are also affected death can be the result.

(*To be concluded.*)

PROCEEDINGS OF THE OBSTETRICAL SOCIETY OF BOSTON.

C. W. SWAN, M. D., SECRETARY.

MAY 12, 1877. *Bright's Disease and Induction of Premature Labor.* — DR. CURTIS read the case: —

Mary D., domestic, single, twenty-two years old, entered the City Hospital February 12, 1877. Her family history was good. She had been well till three months before, when two hours after a meal she vomited blood. Since then she had had pain in the epigastrium immediately after eating, and lasting from one to two hours. In the morning she was dizzy till noon. The face and legs were œdematous; dyspnœa; abdomen enlarged; catamenia absent for six months, though previously regular; no trouble with micturition. Temperature 98.6°; pulse 72.

February 13th. The heart sounds are normal. She has frequent headaches, dimness of vision, and pain in back. The mammæ are enlarged with areolar change. The uterus rises nearly to the umbilicus, and the fœtal heart is heard to the right of the median line and near the pubes. The urine is normal in color, acid, specific gravity 1021, albumen 1.5 per cent., renal epithelium, granular and hyaline casts. She was ordered

℞ Liq. ammoniæ acetatis . . . . . ℥xxijss.
Acidi acetici . . . . . ℥ss.
Ether. chlorici . . . . . ℥i.
Tr. ferri chloridi . . . . . ℥i. M.
℥i., t. d.

and was discharged on February 27th, relieved.

She reëntered the hospital March 6th, on the surgical side, for a sprained back, with œdema of legs, severe and constant headache, nausea, vomiting, and retention of urine. The urine was acid, specific gravity 1020, albumen three per cent., sediment of pus and blood, fine granular and hyaline casts. Marked changes of Bright's disease in retina.

She became drowsy and stupid, and the retention of urine continued.

On March 19th muscular twitchings and other signs of impending convulsions appeared, when she was transferred to the medical side to be delivered. She was dull, but answered rationally; had frequent epistaxis and vomiting. She was ordered dry cups to the loins, followed by a flaxseed poultice, the ammoniated acetate of iron as before, and bitartrate of potash, one half a drachm, freely diluted, three times daily; milk diet.

March 20th. The bladder and rectum having been emptied, the patient was etherized, and the left hand, with considerable difficulty, carried into the small vagina. The os admitted the index finger, which was gradually carried its full length into the cervix. As the latter yielded and opened out, the other fingers and finally the thumb were readily passed in up to the metacarpal articulation; beyond this the hand could not pass. The cervix had now disappeared; the inner os, thin as a knife-blade and one half an inch deep, surrounded the hand like a collar. In one hour this advance had been made. After three quarters of an hour more no further advance seemed possible, and the pressure of the vagina and os was benumbing the arm. As the breech presented a knee was seized and brought down, but traction on one leg was not successful; the second was brought down, when the breech and a morbidly large belly were delivered; the arms were then disengaged, but no amount of traction could free the head from the embrace of the os. Finally the traction separated the trunk from the head; the latter was then perforated and removed by hand. It was hydrocephalic. The placenta was either adherent, or else so clasped by the uterus that it could be removed only with great difficulty; a part of its uterine face was ragged, as if it had been adherent. There was not a great deal of blood lost, but at the end of the operation the pulse flagged, and the woman was very weak. After the delivery of the head an enema of two ounces of brandy and two drachms of ergot was given. The uterus contracted well; hand pressure was kept up for an hour, when the binder was applied. Dilatation was begun at fifteen minutes before one o'clock; at quarter past three the placenta was delivered. The child was a male, weighed three and one fourth pounds, was thirteen and one half inches long; size about chest under arms eight inches, about thigh two and three fourths inches; fronto-occipital circumference nine inches. The bones of the head were very loose; the fontanelles large; abdomen very full, but not measured; legs and arms spindling; testicles not descended; finger-nails well formed, toe-nails partially.

On the morning of the 20th the temperature of the patient was 98.9°, the pulse 100 On the evening after the operation the temperature was 99.9°, the pulse 100. She was quiet, and had no pain, though somewhat anxious. Enemata of beef tea and brandy were given every two hours. At ten P. M. she was quiet, and taking food by the mouth.

March 21st. A. M. Temperature 99.4°. P. M. Temperature 100.3°; pulse 96. Slept but little during the night, but was quiet. Decubitus dorsal; abdomen tender, but has no severe pain; complains of weakness and vomiting; mind clear; no headache; lochia normal.

March 22d. A. M. Temperature 100.9°; pulse 104. Slept last night. Abdomen tender; no sharp pain; lochia offensive; vagina to be syringed every three hours with solution of carbolic acid. P. M. Temperature 102.7°; pulse 112.

March 23d. A. M. Temperature 101.2°; pulse 108. During night complained of great

pain in lower part of abdomen and in thighs. The abdomen is not distended; is soft, and somewhat tender in the right iliac region. She lies with legs extended; takes liquid food well. Urine, since the 20th, has been drawn four times by day, three times by night, as she complains if the bladder fills. P. M. Temperature 103.6°.

℞ Quiniæ sulphatis . . . . . gr. iii.
t. d.

March 24th. Fair night. Temperature, A. M., 101.4°. P. M. 103°. Face drawn; abdomen fuller, but not very tender. Free and offensive discharge from vagina. Patient easy, excepting when she has spasmodic pain in abdomen. Urine turbid and pale, neutral, specific gravity 1016; urea normal; albumen one per cent., sediment, hyaline casts, and oil globules.

March 25th. A. M. Temperature 101.2°. P. M. 104.1°. Frequent vomiting in afternoon and night. Many discharges of scybala.

March 26th. A. M. Temperature 103°. P. M. 102°; pulse 120. Abdomen fuller, but no more painful; overaction of bowels has ceased; discharge from vagina diminished, and less offensive. Patient weaker; refuses food and wine. Respiration hurried; extremities cold; rectum to be washed out. Enemata of strong beef tea and brandy to be given every two hours. P. M. Failing fast.

March 27th. Nine A. M. Died.

March 30th. *Autopsy* by Dr. Bolles at twelve M. Small quantity of turbid fluid in peritonæum. Peritoneal surface of womb and intestines covered here and there with a thin creamy layer of recent lymph. A thick coat of lymph on liver. The *uterus* measured five and one half inches in length by three inches in width. It was pale and flaccid, with numerous small fibromata on its outer surface; this was also partially covered with recent lymph. The os was everted and irregular; somewhat ragged, but not more so than may be found after normal labor. The inner surface of the uterus was soft and irregular, with a grayish decomposing layer in places containing a small amount of offensive semi-fluid substance. The appearances were such as are found after labor. In the *cervix* was a small sinus containing about a drop of purulent matter. In the left broad ligament, at its juncture with the uterus, was a small depot of pus and inflammatory products. The Fallopian tubes were swollen, reddened, and dilated. In the left ovary was a corpus luteum, slightly less than one half inch in diameter; not very distinctly marked, of a yellowish-buff color, thoroughly connected with the ovary. The *kidneys* weighed fourteen and one half ounces. The capsules were easily detached without tearing the renal surface; color red; tubules quite opaque; a marked yellow border at junction of the cones and the cortical portions. The cones were slightly darker than the cortex. In the right kidney were two or three yellowish, purulent, and sloughy-looking spots, not larger than rice grains, situated in the cones. The *liver* was mottled with fatty spots. The *lungs* were congested. The *spleen*, *stomach*, and *intestines* were normal. No metastatic foci were found in the spleen or lungs.

Puerperal Hysteria. — Dr. W. L. Richardson reported the case: —

D. T., born in Roxbury; lives in Boston. Twenty-eight years old; married. Fourth pregnancy, two resulting in still-born children, the last occurring in January, she then being seven months pregnant. She has one living child. Since January she has had no return of her catamenia. About the middle of June she was treated at the Boston Dispensary for falling of the womb. During the two weeks beginning about July 15th she flowed three or four times, the duration of each flowing being but part of a day, the amount being greater than when she was unwell.

About July 25th she began to have a dull headache, which has continued ever since.

July 27th. She began to be troubled with a weak back, swelling of the legs, slight swelling of the face, double and magnified vision. Her urine was dark, heavy, with a sediment, small in amount. She had great and frequent desire to pass water.

July 31st. Worked out all day doing washing.

August 1st. While walking on the street she became unconscious and fell, and was brought home by the police. She remained unconscious for three or four hours, and then became rational, but in a few hours the unconscious state returned; her mind became wandering, and since that time she has alternately, for several hours at a time, been unconscious and wandering and then rational, the duration of either state being longer or shorter and

more or less frequent on different days. While unconscious she wanders in speech, and has some trouble on her mind, as expressed by her words. At times she tosses herself from side to side, striking out wildly with her arms, or tries to get out of bed. She is very strong while under the influence of one of these attacks. Her complaint is of pain in her head and back, especially the former. Her hands are most of the time up to her head, and all her replies, when asked how she feels, are in relation to the pain in her head.

At times she vomits, the matter vomited being streaked with blood. She is a large and apparently a strong, healthy woman. She eats well during her rational periods, and from time to time calls the attention of the nurse to her natural wants. Her bowels are alternately constipated and loose. The above is the history of the case before her entrance to the hospital, as given by her husband.

August 28th. Entered the hospital this A. M. She was brought in a hack, and carried to the ward. After her entrance she was very quiet all day. When spoken to she would answer sleepily, and at times at random. Diet: milk and a little tea. No action of the bowels. Urine evacuated once; amount large, color normal, reaction acid. Albumen none. Specific gravity 1026. Urea normal. The microscope showed a large number of oxalate of lime crystals.

The evening visit found the pulse 70, temperature 97.8°, respiration 20. She slept well all night.

August 29th. During the day she slept but little, being very restless. She had eight convulsions during the twenty-four hours. These turns were characterized by the following symptoms: She first turned over in bed towards the wall, as she said, not to fall out; then with low cries and moans she would throw her arms about, grasping the head-board, if her hands came in contact with it, and toss around the bed, her body bent backwards (opisthotonos). She would not answer when spoken to, and seemed to be wholly unconscious. At times she would complain of her head. These convulsions lasted from ten to fifteen minutes, during which and after for some five to ten minutes longer she remained unconscious, putting her hand to her head and saying, "Oh, my head!" After regaining consciousness she would say, "I had a very bad turn." Twice she vomited about a teaspoonful of blood. Diet: milk, tea, with a little broth and bread.

Her abdomen was very large, and her bowels constipated. Half an ounce of castor oil was ordered with good result, accompanied by a large amount of wind.

She had a good night's rest until midnight, when she had several hysterical convulsions. Her temperature was, A. M. 98.2°, P. M. 98.8°; pulse A. M. 76, P. M. 72; respiration A. M. 24, P. M. 24.

August 30th. Had three convulsions before the morning visit, but was rational a part of the time. Her pulse was 76, temperature 99.2°, and respiration 28.

A careful examination of the patient while she was lying on her back showed the abdomen to be enlarged, — as if at full term, — firm, elastic, tympanitic. Through the abdominal walls the uterus could not be made out, although some resisting body — possibly small fœtal parts (?) — could be felt in the left iliac region. Per vaginam the os and cervix — the latter one and a half inches long — could be felt but unsatisfactorily, owing to the nervous condition of the patient.

The patient was then etherized with the difficulty usually attending the etherization of hysterical patients.

The abdomen, which before the administration of ether had been much larger than is usual in a woman nine months pregnant (its vertical curvature commencing between the breasts and extending to the pubes, and its lateral curvature extending from the back on each side), immediately subsided to the normal size of the abdomen in a woman seven months pregnant, while its tympanitic character disappeared. Beneath the abdominal wall the uterus could be felt rising above the umbilicus about one inch. and easily movable. Per vaginam the cervix could be felt about an inch long and soft, while above it was the uterus, which by combined internal and external palpation showed the date of pregnancy to be about seven months.

There were no signs of preëxisting pregnancy in the abdomen, although there were marks of a previous mammary distention of the breasts. The fourchette and perinæum showed a previous delivery. As she came out from under the influence of the ether the abdominal

tumor commenced to increase, although it did not regain its previous size on the same day with the examination. At the evening visit the pulse was 100, temperature 98.4°, respiration 24.

After recovering from the effects of the ether she had two convulsions, and was very restless and wandering during the afternoon and evening.

August 31st. Slept but little last night, and was very restless. Appetite poor. Was ordered ten grains of chloral and twenty grains of bromide of potassium every three hours. Had two convulsions during the day. During her periods of consciousness she was more rational than before taking the ether. Slept well at night.

September 1st. Condition to-day about the same; had but one slight convulsion.

September 2d. Had only one convulsion. Her general appearance was decidedly improved. As the hospital was crowded, and the patient lacked two months of her confinement, she was sent to the City Hospital, where she could stay until return here at the time of labor. She remained there about ten days, improving daily. She then returned to work, and was confined November 22d, the labor being in every respect normal.

Phlebitis in Consequence of Periuterine Inflammation or Peritonitis. — Dr. Sinclair stated that three cases had recently appeared under his care. In the first case, that of a lady aged twenty-nine, pelvic inflammation followed the catamenia, developing phlebitis, first on the left then on the right side, along the course of the saphenous vein. The second case was that of a lady of forty, who, under similar circumstances, was seized with phlebitis, first of the lower extremities, then of the upper, and then elsewhere, until, finally, there was a general distribution of the disease, from which there was a very slow recovery. To-day he had seen a third case following severe pelvic peritonitis, the result of wetting the feet after the catamenia four weeks ago. At one time the patient's life was threatened from the exhaustion of constant vomiting, during which she was fed by the rectum. Three weeks before pain occurred in the right calf, and the right saphena and the veins of the calf became cordy and painful. Internally there were tender portions of the roof of the vagina on the right side, and excessive tenderness high up on the right side of the uterus. Dr. Sinclair predicted for her a long and severe illness. He remarked that he did not know how common and how much observed this sequence might be, but thought it strange that he should have seen so many cases in so short a time. In the last case the pelvic symptoms came on three or four weeks before the phlebitis, which began internally, and extended down the thigh.

Dr. Chadwick stated that among fourteen hundred patients at his dispensary, and six or seven hundred at the hospital, no such sequence had been observed.

Dr. Homans remarked that he occasionally saw phlebitis after surgical cases, as once in both lower extremities after simple fracture of the thigh. He amputated the leg of a lady who had been run over by the cars; she had phlebitis a few weeks afterwards, when the wound was nearly healed. He did not think that the cases of Dr. Sinclair showed a special liability to the sequence. He had seen the disease in one or both legs several times in typhoid fever cases; as often, in fact, when there had been no pelvic inflammation as when there had been.

Double Uterus and Vagina. — Dr. Chadwick reported the case, which was published elsewhere.

Labor complicated by Fibrous Tumors of the Cervix Uteri. — Dr. Homans stated that he had again (within a week) delivered the patient whose case he had from labor to labor reported at previous meetings of the society. This was the fifth delivery. The original tumor of the posterior lip had grown considerably; it was about an inch and a half from the edge of the lip, and filled the hollow of the sacrum, where it lay apparently not adherent, though immovable, so that the finger could not even be passed behind it. The tumor of the anterior lip was smaller than before. The head presented. The long French forceps were applied, and strong traction made. A living child was delivered, which bore upon its head marks of the forceps, such as indicated that a good deal of force had been used. The delivery occurred at full term, fifteen months from the previous labor. The posterior tumor was as big as the fist, round and smooth, and did not change its position during the passage of the child. The child's head was small.

Fibroid Tumor in the Os Uteri obstructing the Menstrual Flow. — Dr. Lyman reported the case of a lady twenty-two years of age, tortured almost to insanity by the monthly pain of menstruation. On examination he found a curious stoppage of the os in the shape of a small tumor, partially external, which fitted the cervix like an acorn in its cup. Externally it was soft and vascular, and bled on the slightest touch. The attachment occupied nearly the whole of the circumference of the cavity of the cervix, and only admitted posteriorly a sharp-angled silver-wire probe, which after insertion had no lateral movement. The larger portion of it was excised, and was found to be superiorly as hard and firm as any ordinary fibroid.

Imperforate Os complicating Labor. — Dr. Townsend, of Natick, reported the case of an Irish patient in labor at term, to whom he was called in consultation. No os was found at the primary examination, but a slight depression existed at the normal site. The patient had had some uterine disease in the early stage of pregnancy, and had been treated severely by caustics. By the speculum a star-like cicatrix was seen. This was, without great difficulty, broken through by the finger-nail without instrumental aid, the cicatrix being scarcely firmer than the ordinary membranes often are, when the os immediately took the usual form in dilatation, about an inch in diameter, and the labor then went on normally. Some years ago, said Dr. Townsend, Dr. D. H. Storer was called to a similar case, which occurred in Framingham.

Dr. Lyman said that he had heard a good deal concerning the cicatricial contraction of the os from the use of caustics, but that he had never had, himself, any bad results from their employment.

Dr. Richardson remarked that among the out-patients of the Massachusetts General Hospital he had met with several bad cases of cicatrization from the use of caustics. In one instance the entire outline of the os and cervix was lost; in the upper part of the vagina was found a passage to the os, which admitted only the very finest bougie. The patient had been under the care of female physicians, who had applied caustic at frequent intervals for a year and a half.

Dr. Sinclair reported two instances which he had met with in non-pregnant women. One was a case of atresia from the use of caustics. The other

case was his own patient, who was treated for uterine disease, and who, after a year or two, came to him complaining of great pain at the occurrence of the catemenia. He found the os closed and the lips adherent. The removal of the adhesions relieved the pain entirely. The treatment she had received had never in his hands been followed by similar results in other cases.

Relaxation of the Symphysis Pubis as a Result of Parturition. — Dr. Driver, of Cambridge, reported four cases, which will be published. He stated that among the very old writers relaxation was considered to take place regularly as a preparation for delivery. That belief had disappeared, except with regard to some of the lower animals, and some feeble persons. He doubted its being a physiological fact taking place in every way normally. He remarked that the case he had first reported was interesting to him, the previous retroversion having been supposed to be the cause of the symptoms, whereas these were probably due to the condition of the symphysis. He suggested that the length of the first stage was the chief difficulty with late primiparæ.

Dr. Curtis recalled cases of marked separation of the bones in guinea pigs which were exhibited by Dr. Jackson at the meeting of the Boston Society for Medical Improvement.

Dr. Homans stated that he had never seen but one case. In this instance the bones for two or three months after each confinement would occasionally slip while the patient was walking, so that even if she were standing in the street before a coming carriage she would be unable to get out of the way.

Dr. Sinclair said that he had never met with a case which he had been able to recognize as such. As to the statement, which had been made elsewhere that separation does not take place, he was far from thinking so. He was reminded of a lecture by Simpson, who enumerated animals which habitually had this condition.

Dr. Richardson remarked that he supposed it to be well admitted that a physiological relaxation of the pelvic bones of women occurred in the latter stages of pregnancy.

Dr. Lyman mentioned an instance of this affection which occurred twenty-five years ago. The patient had had twins, and the relaxation was so marked that the pelvic bones could be moved freely and largely upon each other in both a vertical and a lateral direction. Her locomotion was seriously affected, especially the going up and down stairs. The affection in this patient was complicated with considerable œdema, which in the morning occupied the neck and chest, in the evening the lower parts of the body. Dr. Lyman remarked that opinion upon this question had, of late years, undergone great change, the majority of the best writers of the present day believing relaxation to occur in *some degree* in all cases of labor.

Dr. Ingalls stated that he had never met with but one instance of relaxation of the symphysis. In this case there was trouble for one or two months, the patient being unable to walk about with comfort, and complaining of the pelvis. A leather belt gave her a great deal of comfort. In the cases exhibited by Dr. Jackson, of rats and mice, in which the bones had been separated to a considerable extent, the interval was supplied with strong ligamentous substance. Dr. Ingalls said he had no doubt that very many animals do have this separation.

Dr. Hosmer said that he had had a single case under his observation. He heard the friction sound and felt the motion of the loose bones, but there was no pain nor serious disability. Assuming the relaxation to be physiological, said Dr. Hosmer, may it not have to do with the difficulty of the labors of primiparæ of advanced age?

Dr. Lyman stated it as his belief that it did not.

Dr. Richardson asked if the second stage of labor in late primiparæ was not longer than the same stage in young primiparæ.

Dr. Hodgdon said he had always found greater resistance of the perinæum among first labors at an advanced age.

Dr. Ingalls stated as the result of his experience that first labors of patients between the ages of thirty and forty were not really different, whether in regard to severity or duration, from those of women between the ages of twenty and thirty. Taking a considerable number of the former class, he would not expect to have greater difficulty with these than with the same number of younger parturients.

Novel Method of surmounting the Difficulties of Labor. — Dr. Ingalls said that on entering the lying-in room, once upon a time, in an obscure village, he was taken quite aback by a startling group: the parturient lying upon her side, and a large woman seated upon her pelvis.

DR. JOHN B. BIDDLE.

PROFESSOR OF THERAPEUTICS AND MATERIA MEDICA AT THE JEFFERSON MEDICAL COLLEGE, PHILADELPHIA.

Hall of Jefferson Medical College, Philadelphia, *January* 20, 1879.

At a meeting of the faculty, held this day, the death of Dr. John B. Biddle, professor of therapeutics and materia medica, and dean of the faculty, was announced; whereupon the following was ordered to be entered upon the minutes of the faculty: —

"The faculty of Jefferson Medical College find themselves plunged into the deepest sorrow by the death of their fellow-member, Dr. John B. Biddle, professor of therapeutics and materia medica, and dean of their body, which occurred on the evening of the 19th inst. As a friend, they feel sadly the void thus created, and mourn over the departure of a greatly loved companion. Endeared to them by his noble qualities of head and heart as their colleague and executive officer, they realize the irreparable loss of a sound and sagacious thinker, an able and successful teacher, and a faithful, experienced, and judicious executive, whose untiring zeal and earnest labors in his own department, and for the school at large, have contributed so much to maintain the usefulness and advance the reputation of Jefferson Medical College.

"The faculty feel that words are inadequate to express their sense of this bereavement, but desire to make record of the estimate in which they held the deceased, whose memory they will ever cherish with sincerest affection.

"They desire to convey to his sorrow-stricken family their warmest sympathy, trusting that in the knowledge they have of the esteem in which he was held in the community, and the love which was borne him by all his co-laborers and friends, and that he has left them in the assurance of a Christian faith for that larger life which is eternal, they find comfort and consolation.

"*Resolved*, That a copy of this testimonial be transmitted to the family of Dr. Biddle, and also to the honorable board of trustees; and that the faculty will attend his funeral in a body. (Signed) Ellerslie Wallace, *Dean*.

As will be seen from the foregoing resolutions of respect and condolence, Professor John Barclay Biddle, dean of Jefferson Medical College and president of the Association of American Medical Colleges, died on the 19th of January, 1879. He had been suffering from a typhoid condition, complicating an attack of pleurisy, for about a fortnight, but was not considered as dangerously ill until the day before he died. The announcement of his death was a shock to the profession, and a severe loss to the community, by whom he was universally respected and esteemed. He occupied a prominent position in social circles, and held some important trusts. He was president of the directors of the County Prison, attending physician to the Girard College and to the Institution for the Deaf and Dumb, and consulting physician to a number of local charitable institutions.

Professor Biddle was born in Philadelphia in 1815, and was educated at the University of Pennsylvania, from which he received his diploma in March, 1836. After spending several years in Paris, he returned to his native city, and at once took an active interest and a prominent position in professional matters. His *clientèle* was select but never extensive, as he preferred a consulting to a private practice. He was professor of materia medica in the Franklin Medical College, and afterwards in the Pennsylvania Medical College, both of Philadelphia. Upon the death of Dr. T. D. Mitchell, professor of materia medica and therapeutics at Jefferson College, Dr. Biddle was elected in the fall of 1865 to the position, which he occupied up to the present time. Dr. Biddle was one of the editors of *The Medical Examiner*, a bi-weekly, afterwards a monthly journal, published in Philadelphia from the year 1838 to 1844, then merged into the *North American Medico-Chirurgical Review*. He had not, of late years, been a frequent contributor to medical literature. His work on Therapeutics and Materia Medica, designed as a class-book for students, was well received by the profession, and has now reached its eighth edition.

THE EDUCATIONAL MOVEMENT IN PHILADELPHIA.

At the last meeting of the state society great interest was shown in the question of raising the standard of medical education, and several significant resolutions were adopted. The first one made it incumbent upon the county societies to elect three members to be called medical examiners, "whose duty it shall be to examine all applicants for admission as students of medicine under the tuition of members of this society; and said committee shall withhold their certificate from any applicant unless he is of good moral character, and possesses a good English education and a sufficient knowledge of Greek and Latin to enable him to pursue his studies with advantage. And no member of any county society shall receive any person as a student of medicine unless he present a favorable certificate from this committee."

Other resolutions were adopted, requiring students to enter into a written contract with their preceptor to pursue their studies for not less than three years; and, finally, it was made "the duty of all members of the profession owing allegiance to the Medical Society of the State of Pennsylvania to recommend their students to attend only such medical colleges as rigidly enforce

the full three years' course of study in their curriculum, and otherwise conduce to raise the standard of graduation."

Whilst an endeavor is being made to increase the value (and expense) of the degree, on the other hand, the emoluments and rewards appear to be steadily declining. This is due to several causes: there is, first, the reaction from the exorbitant estimates placed upon their services by physicians, which in flourishing times passed without complaint, but which are now criticised, and often opposed; and, secondly, the unrestrained competition of the public dispensaries encourages patients of every degree to enjoy the material advantages they freely offer.

ILLINOIS STATE EXAMINATIONS.

We have received from the Illinois State Board of Health a list of the examination papers offered at its annual examination, held in Springfield January 16th. The board was organized in July, 1877, and in addition to its other functions exercises that of a licensing body. Its career will therefore be watched by other States with considerable interest. The papers before us give evidence of the thorough character of its work. We find here examinations in anatomy, surgery, materia medica, and therapeutics; hygiene, medical jurisprudence, practical medicine, physiology, diseases of women, general pathology, obstetrics, and chemistry. All physicians residing in the State who had practiced less than ten years, or who could not furnish evidence of good professional standing, were subjected to the examination of the board at the time the new law went into operation. The papers are elaborate, and demand a high standard of excellence from the candidate. Midwives were also obliged to undergo an appropriate examination. The statistics of licenses hitherto issued by the board, which we believe are of several grades, bring out some interesting facts in regard to the different so called schools of medicine. The total number of licenses issued in the State is 4950. This number is divided up as follows: regulars 3646; homœopaths 437; eclectics 456; physio-medicals 37; not stated 336; all others 38. The expenses of the board have been about $8000 thus far. A glance at the figures here given show a very striking disproportion between the number of regular practitioners and the "pathies." Evidently the demands of a general high standard of education to all who wish to be doctors are discouraging to irregular modes of practice. We should be glad to see some form of license law established in this State, where quacks thrive as they do nowhere else. Should they succeed, as we understand they are attempting to do, in abolishing the law in Illinois, we may possibly be partially relieved from the present pressure.

MEDICAL NOTES.

—In his inaugural address Mayor Prince strongly recommended the placing of the city registrar's department under the Board of Health. The change is one that should long ago have been made. Recently a circular has been sent to the physicians of the city by one of the leading undertakers, asking for signatures to a petition in favor of the proposed change. It is to be hoped that

the members of the profession will reply favorably to the application, in order that there may be no unnecessary delay in consolidating the two offices.

— In its edition for January 8th the *Medical Press and Circular*, having entered upon its *forty-first* year, congratulates itself upon being, with the exception of the *Lancet*, "the oldest medical journal now published in the English language." The fact is, it is more than a decade younger than the Boston Medical and Surgical Journal, which was ushered into being February 19, 1828, while the *American Journal of the Medical Sciences* is now in its forty-eighth year, and consequently older even than the *Lancet* by three years.

— The *Doctor*, a bright, English medical journal, has been discontinued.

— The *British Medical Journal* and the *Medical Times* have begun the year with cut leaves. The *Medical Press and Circular* has had the good sense thus to consult the convenience of its readers for several years, and we wish every periodical in existence would follow suit.

— In the *Lancet* Dr. Gowers recommends the following solution for the necessary dilution of blood when one wishes to count the corpuscles: "Sulphate of soda one hundred and four grains, acetic acid one drachm, distilled water four ounces." Dr. Gowers has found it superior to any other solution.

— In Professor Simpson's very interesting paper on the Gleanings from a Continental Tour, published in the *Edinburgh Monthly* for January, he congratulates the profession of Great Britain upon the good society work of their country, and believes that the quality of medical teachers is improved by the broadening and instructive effect of society discussion. He adds: "The want of similar societies among the Germans is a serious defect in their system of medical education. We look in vain through their calendars for the name of one where medical topics are likely to be discussed. Only in connection with one university do we find mention of such a society. When I asked one of the professors what was the nature of this Cœtus Anatomicus, as it is designated, he said he had not heard anything of it, but added, "Probably there is more 'supper' than 'anatomy' about it."

— Referring to "forcible fractures" of bones for osseous anchylosis, Mr. Bryant lately stated, at Guy's Hospital, that he had seen three cases so treated, "one of whom escaped only by the skin of his teeth, the other two dying of acute abscess of the joint." In such cases he preferred Adams's operation of subcutaneous osteotomy.

— Professor Penrose recommends vinegar in post-partum hæmorrhage for the following reasons: (1.) It can be easily obtained. (2.) It can be easily applied, and instantly, without special apparatus. (3.) It always cures the hæmorrhage, or rather it has not failed in his practice. (4.) It is sufficiently irritating to excite the most sluggish uterus to contraction, and yet not so irritating as to be subsequently injurious. (5.) It is an admirable antiseptic. (6.) It acts upon the lining membrane of the uterus as an astringent. The remedy is applied as follows: saturate a rag with vinegar, carry it into the cavity of the uterus, and squeeze it.

— Dr. Murchison says: (1.) The duration of the incubation stage (of scarlatina) may be only a few hours. (2.) Probably in a large proportion of cases it does not exceed forty-eight hours. (3.) It very rarely exceeds seven

days. (4.) Consequently, a person who has been exposed to scarlet fever, and does not sicken after a week's quarantine, may be pronounced safe. He thinks, too, that facts prove the infecting power of scarlet fever from its earliest stage, although probably it is less during the first two or three days than a case of measles. On the contrary its power of infection may extend over a period of many weeks. To pronounce a patient out of danger at the end of a month, after the apparent cessation of desquamation, is not always safe. He considers it a good rule to consider no case safe until after the eighth week.

— In the case of a lady who had taken huge doses of morphia daily for seven years, her child was active and lively in the womb, and is and always has been perfectly strong and healthy. The *Lancet* reports the case. The morphia was suddenly discontinued with interesting results, which will be found in a December number of the *Lancet*.

CHICAGO.

— Prof. E. L. Holmes presented to the meeting of the West Chicago Medical Society of January 13th a specimen of tuberculous choroid. The specimen was taken from a case dying at the County Hospital, in which there was a deposit of miliary tubercles in nearly every organ of the body. It came into Dr. Holmes's hands from the pathologist of the hospital, Dr. Fanger, who Dr. Holmes declared was the first physician in the Northwest who had examined the choroid for tubercles, "for the purpose of verifying the clinical fact that the choroid is often implicated in acute miliary tuberculosis."

The tubercles in this case were eight in number, and were all located in the posterior half of the eye. This was the usual location. He remarked that the choroid was a favorite site for the deposit of tubercles. As they were usually located posteriorly in the eye, and reached a size often of more than a line in diameter, they could be detected by the ophthalmoscope during life, and when in any case they were found here the presumption would be strong that they existed elsewhere in the body, and especially in the meninges. It was a curious circumstance that no one had reported the detection of any aberration of vision in cases of this kind. Theoretically, disturbance of vision should be expected in such cases. He thought more careful observations ought to be made on this point.

LETTER FROM VIENNA.

Chrysarobin and Pyrogallic Acid in some Forms of Skin Disease.

THESE substances, of analogous chemical composition and action, have attracted much notice during the past year, because of their efficacy against psoriasis and several other diseases of the skin; and a short account of the results ensuing from the use of these remedies in Vienna practice may perhaps be of interest.

Chrysarobin is obtained from Goa powder, and was introduced to the profession by Mr. Squire, of London, under the name of chrysophanic acid; Liebermann, of Berlin, however, has shown that chrysophanic acid and the derivative of Goa powder, although allied, are not identical substances, and he has called

the latter chrysarobin. Therapeutically the best results from the use of this drug have been gained with an ointment consisting of chrysarobin five, ten, or even twenty parts, and unguentum emolliens, or vaseline, one hundred parts, the proportions being varied in each particular case, according to the obstinacy of the disease or the sensitiveness of the skin. With regard to psoriasis, the advantages of this ointment are that it has no odor, and when brought in contact with a wounded surface does not cause pain, that several *plaques* disappear within a few days, and that, as a rule, the treatment is speedy and efficacious; of course, a radical cure is not obtained, for the disease recurs, as it will after the use of any remedy. Most suitable for treatment with this ointment are those cases of psoriasis in which the plaques are few in number, or are, at all events, isolated, of long duration, and have but little tendency to increase in size. The diseased spots must be vigorously washed with soap and water to remove the thick layer of epidermis, or, if very abundant, it may be scraped away with the sharp spoon; then, with the tip of a small, stiff brush the salve is rubbed into the various plaques until it leaves a yellow color. Too much salve should not be applied, as it strongly irritates the neighboring skin, over which it is certain to become diffused. Only one application, or at most two, daily are necessary. The plaques should now be powdered or covered with cloth, as chrysarobin stains everything with which it comes in contact. After from six days to three weeks, according to the size and character of the plaques, the local appearances of the disease have vanished, each plaque being covered with a smooth epidermis, but containing little or no pigment, and therefore much whiter than the surrounding skin, a condition which remains for a long time. In simplicity of application and rapidity of action this remedy surpasses everything hitherto used. Unfortunately, however, there are peculiar drawbacks attending the use of chrysarobin. When it has been brought in contact with the epidermis of the healthy skin, or with the nails, it gives a violet-brown color, especially noticeable after the use of soap. When it has been applied to the face or scalp the hair takes on a yellowish or dirty-greenish tint. Then chrysarobin is very prone to excite inflammation. In nearly every case, after from four to fifteen applications, the psoriatic plaque is surrounded by a bright red halo, just at the time the plaque itself begins to fade. On the appearance of this erythema the salve should be discontinued, when the inflammatory process will probably cease, and wholly disappear after a slight desquamation of the epidermis. Very often, however, the inflammation spreads; the erythema passes into a diffuse dermatitis, attended with pain, intolerable itching, fever, and enlargement of the glands. In some cases there appear around the mouths of the follicles countless nodules of a brownish-red color, slightly elevated above the surface of the skin, and often surmounted by a vesicle or pustule; finally, furuncles may be formed in great number. The face and genitals are peculiarly susceptible to the irritant action of chrysarobin, œdema and inflammation occurring whenever the salve is applied to these regions.

To recapitulate: (1.) Isolated plaques on the body and extremities are better suited for the use of chrysarobin than all other forms of psoriasis. (2.) Psoriasis of the face or genitals should never be treated with chrysarobin, and

the same may perhaps be said of psoriasis punctata, where the process is acute. (3.) As it is a remedy liable to give rise to most unpleasant symptoms, chrysarobin should be applied only under the personal supervision of the physician.

As pyrogallic acid is chemically allied to chrysarobin, Dr. Jarisch, assistant in Hebra's wards, instituted a series of experiments to ascertain whether these substances worked analogously in their action upon the skin. The results attending these experiments have been more than satisfactory. Dr. Jarisch makes use of an ointment containing ten parts of pyrogallic acid and ninety parts of unguentum emolliens. For psoriasis this salve is applied twice daily in the same manner as described for chrysarobin. It has an objectionable feature in that it stains the epidermis brown wherever applied, and this discoloration remains during several weeks. The duration of treatment varies from ten days to three weeks or more, somewhat longer than with chrysarobin, but decidedly shorter than with the older methods. The advantages of pyrogallic acid may be summed up as follows: (1.) When applied to the scalp the hair is unchanged, or the color is only slightly darkened. (2.) It never causes inflammation around the psoriatic plaques to which it is applied, and therefore may be used upon the face without fear of œdema and conjunctivitis. (3.) Since the salve does not irritate the skin *in toto*, as chrysarobin does, it is a remedy which can be trusted to the patient's own hand.

Pyrogallic acid has also been successfully experimented with in cases of lupus vulgaris. A salve containing ten per cent. of the acid is spread on cloth, closely applied to the diseased part, and renewed twice during the day. The lupus nodules soon take on a brownish-gray color, become œdematous, and project somewhat above the level of the surrounding skin. After from five to six applications, that is, after two or three days, the spots of lupus are totally necrosed and fall out, and the salve may be discontinued. The bridges of healthy skin between the nodules have in the mean time become superficially cauterized, are reddened, swollen, and sensitive, and the epidermis is loosened. After removal of the acid the swelling subsides, the defects in the skin left by removal of the lupus nodules heal by granulation, the epidermis is renewed, and in no place has healthy tissue been destroyed; only wherever a lupus nodule has existed there remains a corresponding cicatrix. The action of the salve is entirely local and confined to the surface with which it comes in contact. During the first two days of treatment many patients complain of pain, but no method for curing lupus is free from this drawback. Pyrogallic acid alone destroys each spot of infiltration, leaves intervening healthy tissue intact, and causes inflammation only where it is applied. Thus far the results have been very gratifying, and I need only mention that of twenty-four cases of lupus, many of which had been for a long time in the wards, nineteen were, after a few weeks' treatment with pyrogallic acid, so far relieved that they were discharged from the hospital.

Several cases of epithelial carcinoma, under continued application of a twenty per cent. pyrogallic acid salve, have been cured, the new growth becoming necrosed in a few days. The epithelial cell, however, opposes more than ordinary resistance to the action of the acid, and it is doubtful if other

than very superficial forms of epithelioma can be thus treated with success. The action of pyrogallic acid on other cell infiltrations, such as lupus erythematosus, prominent cicatrices abounding in young connective tissue, ulcerating gummata, etc., has been favorable enough to warrant further experiments in this direction.

J. E. GARLAND, M. D.

VIENNA, *November* 20, 1878.

SHORT COMMUNICATIONS.

JAMES WATSON ROBBINS.

DIED, in Uxbridge, January 10, 1879, James Watson Robbins, M. D. By the death of Dr. Robbins, the general public, as well as a large circle of more intimate friends, have suffered a loss which cannot readily be repaired. As a "beloved physician" he enjoyed to the end of life the deep-seated regard and affection of all those among whom his professional services were dispensed. His affability and kindness of manner at the bedside of the sick, as well as his skill in the treatment of disease, will be missed in many households. In his intercourse with his professional brethren Dr. Robbins always sustained the character of an upright, honorable, and conscientious man.

Dr. Robbins was born in Colebrook, Ct., November 18, 1801, and was the eldest of Ammi Ruhama and Salome R. Robbins. He fitted for college with Rev. Ralph Emerson, of Norfolk, Ct., and entered Yale College in September, 1818. Upon his graduation, in 1822, he taught school for four months in the town of Enfield, Ct. From this place he was engaged at Pamunkey Creek, Prince Charles's County, Md., as a teacher in the family of William L. Brent, then a member of Congress from Louisiana. Removing with Mr. Brent to Georgetown, D. C., he spent the year 1824 in his family. In 1825 and 1826 he had a school in the family of Dr. Chandler Peyton, at Gordonsdale, Fauquier County, Va. Among his pupils was Robert E. Lee, late commander of the rebel armies. Under the doctor's tuition Lee was fitted for an entrance into the United States Military Academy at West Point

While in college Dr. Robbins acquired a love for the study of botany, and through all his future life continued a devotee to his favorite pursuit.

His medical studies were pursued under the direction of Professor Ives, of Yale College, and he was admitted to the degree of M. D. in 1828. About this time the United States government contemplated an exploration of the Shetland Islands, then recently discovered in the Pacific, and, had not the organization of the expedition failed, upon the recommendation of Professors Tully and Ives, Dr. Robbins would have been appointed its botanist.

In 1829 he made an extended tour through the New England States, examining and collecting specimens of their flora. The expense of this expedition was defrayed by William Oates, of Ipswich, and for his time and labor Dr. Robbins was to retain one half of the specimens collected. When it is understood that most of this journey was made on foot it will indicate the zeal and assiduity with which Dr. Robbins continued to prosecute his favorite study.

He came to Uxbridge in 1830, and entered into a copartnership with the late Dr. George Willard in the practice of medicine. This partnership was not of long duration, and from its close to 1859 he continued his residence at Uxbridge, neglecting no opportunity to make additions to his already large and valuable herbarium.

In that year he was engaged as physician and surgeon at the Pewabic Copper Mines, on the shore of Lake Superior. The opportunity it would afford him to study the plants of a more northern latitude was, without doubt, an additional reason for his acceptance of this position. After four years of service at the mines he started on an extended tour of observation for the purpose of enlarging the boundaries of his favorite science. Passing through Michigan and Illinois, he took passage for New Orleans in one of the first boats for that city after the Mississippi had been reclaimed from rebel occupation. After a short stay at New Orleans he took passage for Cuba, by the way of Texas, and arrived there in February, 1864. Three months were spent in the neighborhoods of Havana and Matanzas in the examination and collection of botanical specimens. Returning to Uxbridge, Dr. Robbins resumed the practice of medicine, in which he continued to the close of life. But

for his modesty and reticence he would long since have held a more generally acknowledged distinction among the masters of that branch of natural history to which he devoted his life. The extensive correspondence which he held with the leading botanists of this country, as well as those of Europe, furnishes abundant testimony of the regard in which he was held as an intelligent and reliable *confrère*. It is understood that Dr. Robbins rendered valuable service to Professor Gray in his botanical researches, especially in the genus *Potamogeton;* and in recognition of his aid one of the species first described by Dr. Robbins is named *Potamogeton Robbinii*. The plants collected by the government exploration of the fortieth parallel were submitted to him for their classification and arrangement. At the time of his decease he was engaged in the examination of a large collection of the flora of California.

M.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

At the January quarterly meeting, being its thirtieth annual session, the society again unanimously reëlected Dr Henry H. Smith as its president, a deserved tribute to an efficient and experienced chief officer, who now enters upon his third term of service. The other officers of the society for 1879 are as follows: Vice-Presidents, Drs. R. Burns and J. H. Packard; Treasurer, Dr. W. M. Welch; Corresponding Secretary, Dr. W. Goodell; Recording Secretary, Dr. C. B. Nancrede; Assistant Recording Secretary, Dr. J. D. Nash; Reporting Secretary, Dr. F. Woodbury; Librarian, Dr. M. O'Hara; Censor, H. St. Clair Ash. The following were chosen to represent the society as delegates to the American Medical Association: H. St. Clair Ash, Robert Burns, John B. Biddle, W. R. D. Blackwood, Thomas M. Drysdale, L. A. Duhring, Albert Fricke, Samuel D. Gross, William Goodell, N. L. Hatfield, Charles K. Mills, James H. Hutchinson, R. J. Levis, Benjamin Lee, Henry Leaman, Andrew Nebinger, Michael O'Hara, William H. Pancoast, William Pepper, John H. Packard, H. H. Smith, George Strawbridge, Samuel N. Troth, George B. Wood, Horatio C. Wood, Jr. To the Medical Society of the State of Pennsylvania: Samuel Ashhurst, Harrison Allen, W. L. Atlee, Jr., Harry F. Baxter, F. J. Buck, Wilson Buckby, W. H. Baker, Edward T. Bruen, William H. Bennett, J. H. W. Chestnut, J. Solis Cohen, R. A. Cleemann, W. R. Cruice, Robert B. Cruice, R. J. Dunglison, Horace Y. Evans, H. Lenox Hodge, N. Hatfield, George Hamilton, L. B. Hall, William Hunt, Charles T. Hunter, F. P. Henry, S. R. Knight, Philip Leidy, J. Aitken Meigs, John A. McArthur, Caleb W. Hornor, George R. Morehouse, Edward J. Nolan, Charles B. Nancrede, H. W. Ozias, W. H. Parish, J. R. Partenheimer, S. D. Risley, John B. Roberts, John G. Stetler, E. I. Santee, F. G. Smyth, J. D. Schoales, E. O. Shakespeare, J. V. Shoemaker, A. H. Smith, Laurence Turnbull, William T. Taylor, James Tyson, William M. Welch, Charles F. Wittig, John E. Whiteside, Frank Woodbury.

The County Medical Society is now in a flourishing condition; its meetings are well attended, and the discussions spirited and interesting. It has now about two hundred and fifty active members, among which may be noticed the names of nearly all the prominent men of the profession in Philadelphia.

THE ST. LOUIS JOURNALS.

A CORRECTION.

We have received several exceptions taken by physicians of St. Louis to remarks made by a correspondent in a recent letter from that city in reference to the St. Louis *Medical and Surgical Journal*. This journal is one of the oldest in the country, being now in its thirty-sixth year, and has always been ably edited. We therefore are happy to quote the following extract from a communication since received from our correspondent: —

"In a letter from St. Louis, published in your issue of January 9, 1879, your correspondent made the following statement: 'Long since dissatisfied with our local medical press, the representative men of the city and State have associated themselves, with an abundant capital, for the purpose of establishing a monthly periodical,' etc. It has been suggested to the writer that this assertion was rather too comprehensive in character. As your corre-

spondent has no desire to prejudice any one's interests, he wishes to modify his statement by inserting the word *many* in the sentence above, so that it will read *many* 'representative men,' instead of '*the* representative men.' Otherwise the facts remain unaltered."

The old journal has evidently still many warm friends. We take this opportunity, however, to call attention to the new journal, the *St. Louis Courier of Medicine and Collateral Sciences*. It is a monthly periodical bound in neat covers, with a fine vignette of John Hunter figuring above the table of contents. The contributions are of the most varied character, containing a large number of original articles, translations, book reviews, society reports, editorials, etc. It is one of the most stylish journals in appearance that we have on our exchange list. Our Missouri colleagues are evidently of a literary turn of mind.

REPORTED MORTALITY FOR THE WEEK ENDING JANUARY 18, 1879.

Cities.	Population.[1]	Reported Deaths in each.	Annual Death-Rate, per 1000 during the Week.	Percentage of total Deaths from				
				The Principal "Zymotic" Diseases.	Pneumonia.	Diphtheria and Croup.	Scarlet Fever.	Diarrhœal Diseases.
New York	1,085,000	632	30.34	20.25	12.97	4.43	10.75	0.79
Philadelphia	—	361	—	—	10.25	3.82	1.66	—
Brooklyn	564,400	246	22.62	21.55	12.20	6.91	8.18	0.41
St. Louis	—	120	—	13.33	12.50	6.67	—	0.83
Chicago	—	161	—	21.74	9.32	13.66	3.73	—
Baltimore	365,000	163	23.28	12.30	14.72	4.30	2.45	—
Boston	356,500	157	22.97	21.02	12.74	16.56	2.55	—
Cincinnati	—	125	—	34.40	7.20	12.80	19.20	1.60
District of Columbia	—	71	—	12.68	15.48	5.63	1.41	2.82
Pittsburgh	—	51	—	17.65	9.80	9.80	1.96	—
Milwaukee	—	33	—	30.30	9.09	27.27	—	3.03
Providence	101,000	49	25.25	26.53	8.16	12.24	10.20	—
New Haven	—	31	—	12.84	9.68	12.90	—	—
Charleston	—	35	—	20.00	5.71	8.57	—	—
Worcester	52,500	19	18.87	31.58	15.79	15.79	—	—
Cambridge	51,400	23	23.32	21.74	13.04	8.69	8.69	—
Fall River	48,500	29	31.18	20.69	3.45	3.45	10.34	—
Lawrence	38,200	17	23.21	11.76	23.53	11.76	—	—
Lynn	34,000	17	26.08	17.65	17.65	11.76	—	—
Springfield	31,500	13	21.52	7.69	7.69	7.69	—	—
New Bedford	27,000	—	—	—	—	—	—	—
Salem	26,400	6	11.35	—	33.33	—	—	—
Somerville	23,350	7	15.63	71.43	—	57.14	14.28	—
Chelsea	20,800	5	12.54	—	40.00	—	—	—
Taunton	20,200	9	23.23	44.44	22.22	22.22	11.11	—
Holyoke	18,200	10	28.65	40.00	—	40.00	—	—
Gloucester	17,100	8	24.39	12.50	25.00	—	—	—
Newton	17,100	9	27.44	—	22.22	—	—	—
Haverhill	16,300	7	23.86	42.86	28.57	42.86	—	—
Newburyport	13,500	10	38.62	—	50.00	—	—	—
Fitchburg	12,500	6	25.08	—	—	—	—	—

[1] Estimated for July, 1879.

Two thousand four hundred and thirty deaths were reported; 332 from consumption, 290 from pneumonia, 151 from diphtheria, 146 from scarlet fever, 114 from bronchitis, 49 from croup, 37 from typhoid fever, 30 from whooping cough, 14 from diarrhœa and dysentery, 14 from erysipelas, 13 from cerebro-spinal meningitis, 2 from measles, one from cholera infantum (in Boston), none from small-pox.

From *bronchitis* 42 deaths were reported in New York, 20 in Brooklyn, 14 in Philadelphia and Chicago, six in St. Louis and Baltimore, five in Cincinnati, two in New Haven, one in Pittsburgh, Milwaukee, Providence, Taunton, and Gloucester. From *typhoid fever*, nine in Philadelphia, five in New York and Baltimore, four in St. Louis, Chicago, and Charleston, three in Brooklyn, two in Pittsburgh, one in Providence and Taunton. From *whooping-cough*, 11 in New York, nine in Brooklyn, two in Baltimore, Cincinnati, and Fall River. From *erysipelas*, seven in New York, two in Brooklyn and St. Louis, one in Chicago, Baltimore, and Boston. From *cerebro-spinal meningitis*, four in New York, two in Chicago, one in Brooklyn, District of Columbia, Worcester, Cambridge, Lynn, Taunton, and Gloucester. From measles, one in Baltimore and Worcester. The returns from seventeen of the nineteen cities in Massachusetts, with a population of 819,500, show a considerably in-

creased mortality from diphtheria; decreased from scarlet fever and acute lung diseases. Diphtheria still prevails in San Francisco, Cleveland, and New Orleans. There is a general epidemic of influenza in Providence.

Sergeant Purssell's meteorological record for the week, in Boston, is as follows: —

Date.	Barometer.	Thermometer.			Relative Humidity.				Direction of Wind.			Velocity of Wind.			State of Weather.			Rainfall. (Melted Snow.)
	Daily Mean.	Daily Mean.	Maximum.	Minimum.	7 A. M.	2 P. M.	9 P. M.	Daily Mean.	7 A. M.	2 P. M.	9 P. M.	7 A. M.	2 P. M.	9 P. M.	7 A. M.	2 P. M.	9 P. M.	Amount in Inches.
Jan. 12	30.21	22	30	15	67	72	65		NW	NW	NW	6	1	6	F	F	C	—
" 13	29.94	29	43	17	71	88	77	62	NW	W	SW	2	9	13	O	O	C	—
" 14	29.91	30	38	24	75	53	69	65	W	NW	W	7	12	10	F	C	F	—
" 15	30.37	6	28	9	55	38	48	47	NW	W	NW	12	16	9	C	O	C	—
" 16	30.02	11	20	1	74	85	80	79	N	N	N	4	8	19	S	S	O	—
" 17	30.29	21	32	8	61	64	73	66	W	S	S	7	3	5	F	F	C	—
" 18	29.79	32	38	28	89	63	67	73	S	W	W	11	16	8	R.	C	C	—

	Barometer.	Thermometer.	Humidity, Saturation being 100.	Wind.	Rain.
Weekly Summary.	Mean 30.081	Mean 22.8	Mean 65.5	Total miles traveled, 1467.	Total amt. 1.11 in.
	Max. 30.39	Max. 39	Max. 89		
	Min. 29.69	Min. 4	Min. 38	Prevailing direction, N. W.	Duration, 19 hrs. 10 min.
	Range 30.70	Range 35	Range 51		

Barometer corrected for temperature, elevation, and instrumental error.

Explanation of weather symbols: O, cloudy; C., clear; F., fair; Fg., fog; R., rain; S., snow; L. S., light snow; T., threatening.

Station: Latitude 42° 21′; longitude 71° 4′; height of instrument above the sea, 77.5.

The death-rate for the week ending January 4th was for the twenty large English towns, with a population of 7,383,999, 29.1, — a decrease of one per 1000 from the previous week; for London (population 3,620,868) 27.4; Dublin, 50.7; Manchester, 36.6; Liverpool, 32.9; Glasgow, 30; Edinburgh, 25. Small-pox was decreasing in London, but still fatal there and in Dublin. Diseases of the respiratory organs were generally prevalent; whooping-cough and scarlet fever in some of the towns.

For the week ending December 28th, in one hundred and forty-nine cities and towns of Germany, with a population of 7,427,658, the death-rate was 25.7, — about the same as for the previous week. Infectious diseases remained also about the same. The deaths from diseases of the respiratory organs (508 chronic, 412 acute), diphtheria (212 diphtheria and croup), diarrhœal diseases (142), scarlet fever (93), whooping-cough (58), and typhoid fever (56) showed the highest rates; no deaths from small-pox, typhus fever, or cholera. Diseases of the respiratory organs are widely prevalent in Europe; small-pox quite rife in St. Petersburg, Vienna, and Warschau, mildly so in Paris, Budapesth, Prague, Trieste, and Odessa. Diphtheria is very prevalent in Paris and Vienna, typhoid fever in St. Petersburg and Paris.

ERRATUM. — In JOURNAL, January 16th, page 101, Prof. W. S. Harris should be Prof. W. S. Haines.

THE GYNÆCOLOGICAL SOCIETY OF BOSTON. — The ninety-ninth regular meeting of the society will be held at the Medical Library Rooms, 19 Boylston Place, at two P. M., first Thursday of February. W. S. Brown, M. D., of Stoneham, will read a paper on Ovariotomy in Great Britain and the United States. The profession are cordially invited to be present.

HENRY M. FIELD, M. D., *Secretary*.

BOOKS AND PAMPHLETS RECEIVED. — Twenty-Sixth Annual Announcement, Medical Department, University of Vermont, for the Year 1879.